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Health Proposals of the Administration

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ON THE 18TH OF JANUARY, the President sent to the Congress his recommendations in the field of health. These were five in number and were concerned with strengthening the research program of the Public Health Service, changes in the formula for grants-in-aid in the health field, further extension of the Federal-State Rehabilitation Program, and amendments to the Hospital Survey and Construction Act of 1946, to provide for construction of chronic disease units, nursing and convalescent homes, diagnostic or treatment centers, and rehabilitation facilities. He further recommended the establishment of a Federal reinsurance service to "encourage private and non-private health insurance organizations to offer broader health protection to more families." He also emphasized that "the best way for most people to provide themselves with the resources to purchase good medical care is to participate in voluntary health insurance plans." This recognition of the principle of voluntary prepayment of the cost of health care has been most gratifying to all of those who have labored for many years in this field.

The American Medical Association acting through its Board of Trustees approved in principle all but the reinsurance proposal, shortly following the President's message. They felt at that time and until a specific bill covering the subject of reinsurance was submitted to the Congress that any action approving or disapproving Federal reinsurance should be deferred.

Since bills have now been introduced into the Senate or the House of Representatives covering the several aspects of the President's proposals, brief comments will be made in reference to the most important of them and a more detailed analysis of the proposed reinsurance plan will be undertaken.

The purpose of the first recommendation as expressed in Senate Bill 2778 is to amend section 314 of the Public Health Service Act so as to extend and improve public health services and provide for better use of public health service funds. At present specific grants are made for a list of diseases such as venereal disease, tuberculosis, cancer, heart disease and mental disease and for public health services generally. The bill proposes the elimination of these specific grants and the substitution of three types of grants. One of these is for general public health purposes, one for extension and improvement of public health service, and the third for so-called "unique projects." In the last two categories there is no provision for consultation with state health authorities or with an advisory committee. While we approve the purpose of this bill, we see no reason for separation of grants one and two, and we feel that consultation with the state health authorities is an essential part of a well working program. We feel that the section dealing with "unique projects" can be clarified. The Surgeon-General is given complete authority in this field without benefit of consultation with

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either the state health agencies or a national advisory council. This bill provides that type 3 grants may be made to non-governmental and non-profit organizations and agencies. More specific definition should be given as to such non-governmental agencies. In view of the fact that the commission on intergovernmental relations was created by the 83rd Congress, it seems desirable to await a report of this commission before new legislation, not of an emergency nature, providing Federal grants-in-aid to the states be adopted.

H.R. 8149 and S. 2748 have to do with amendments to the Hospital Survey and Construction Act of 1947, and are intended to implement plans for treatment and diagnostic centers, chronic disease hospitals and nursing homes. A clear definition of what constitutes a treatment and diagnostic center should be a part of the bill. The provision in the original Hill-Burton Act whereby a state authority making a survey would determine priority of need, location, and type of facility necessary to develop a well-rounded system in each state should be included in the present bill. We also believe, and have so advised the Congress, that chronic disease and convalescent hospitals should be set up as part of or contiguous to existing hospitals. A chronic case may become acute and may require general hospital care not available in a chronic disease institution. Patients should be easily transferrable, back and forth, between the chronic division and the more active part of a conventional hospital.

The Senate Bill 3114 and its companion bill in the House 6356, the so-called reinsurance bills, have stimulated a great deal of interest and have provoked considerable controversy. These bills propose to establish a federal corporation with a capital stock of twenty-five million dollars for the purpose of reinsuring certain health insurance plans operated by a commercial or non-profit insurance carrier. The first section of the bill provides for a technical and advisory service in the insurance field. The Department of Health, Education and Welfare is authorized to collect data from all sources concerning morbidity and mortality rates and other significant factual information. This section also provides for a study of organizational procedures and structure, and the distribution of technical advice and information without charge to agencies engaged in providing insurance against the cost of health services. A separate appropriation would be set up for this area of activity.

The second section of the bill proposes to establish a Federal Reinsurance Corporation with a twenty-five million dollar operating capital. This corporation would undertake to insure, not companies, but particular plans acceptable to the Secretary and at a fee, fixed by the Secretary. This would probably be on the basis of a percentage of gross premiums collected by the company. An allowance of one-eighth of the total gross premiums would be set up for overhead and operational expenses. Seventy-five per cent of the losses, if any, incurred by a company under a particular contract would be covered by the corporation.

"NO COMPETITION" CLAUSE NOT CLEAR

All responsibility for administration of the act lies in the Secretary of Health, Education, and Welfare. A National Advisory Council consisting of 12 members appointed by the Secretary and with the chairman appointed by the Secretary is provided in the bill. The council is merely an advisory one. The Secretary is authorized to utilize such state agencies authorized to supervise insurance carriers. However, requirements and standards are prescribed by the Secretary. The Secretary, after reviewing any proposed plan, will fix the reinsurance premium rate at a level necessary to secure the objective of the act. These premiums will be fixed separately for each plan. The renewals will be made on an annual basis. The premium rate will be subject to change on the basis of experience in a preceding year. The bill contains a "no competition" provision. It is not entirely clear as to just how this would be administered. It is stated that "if, in the Secretary's judgment, reinsurance by non-governmental agencies for a plan is available on the terms and conditions, and at a premium rate comparable to those offered under the act and to an extent that would be adequate to promote the purpose of the act, such plans would not be insured by the Federal Reinsurance Corporation."

There are a number of other provisions concerning the legal status of the carrier, financial soundness, reports required, and certification by the state insurance department. It is obvious that the Secretary has quite broad powers and has the authority to prescribe such regulations as may be deemed necessary to carry out the purpose of the act. This purpose is to extend prepayment insurance to the geographical areas not fully covered, to classes of individuals not now fully protected and to make the total overall protections more extensive or more adequate.

The law further provides that the Secretary can prescribe the minimum benefit, limitation on exclusion because of preexisting conditions or specific illnesses, the maximum liability, waiting periods, duration, cancelability and renewability. There are numerous other provisions of this type that are within the authority of the Secretary to prescribe.

Before considering this program it might be well first to take a look at the present status of health insurance. Voluntary prepayment insurance against the cost of hospital care began in the middle 1930's.

Fifteen years ago, in 1939, nine million people carried some form of insurance against this hazard. At present ninety-two to ninety-three million people carry such insurance. In the meantime progress has been made in insuring against the cost of surgical and medical care in hospitals. At present, approximately seventy-five million people carry insurance against the cost of surgical treatment in hospitals and thirty-five million against the cost of medical care. All these programs have been and still are growing rapidly. It is recognized that these various policies vary considerably in their completeness of coverage; nevertheless, the insurance idea has spread to a large percentage of the insurable population. On the basis of those that are insurable, approximately 72 per cent of the population is covered. The percentage of coverage in different states varies widely. In the industrialized states and the industrial centers, the coverage runs from 80 to 84 per cent of the total population. In the more rural states the percentage is much lower and may be in the range of 45 to 50 per cent. This is largely due to greater difficulty of applying the group principle to the rural population, and of bringing educational methods to bear.

It must be recognized, however, that a considerable percentage of the people in this country, because of financial factors, age, unemployment, permanent or temporary disability of fairly long standing, are not insurable. Unemployment figures do not give a true picture of insurability since on the average 60 per cent of the unemployed are unemployed for four weeks or less, and approximately 57 per cent of them have unemployment insurance. The group over sixty-five years of age numbers over thirteen million, the temporarily disabled are approximately four and a half million, 60 per cent of whom are disabled for more than 30 days. The public assistance group approximates five and a half million, 47 per cent of whom are among the aged. There remains the low income group who so far have been either unwilling or unable to purchase prepayment protection. The experience of certain areas indicates that about half of this group are able to purchase insurance, but are unable to pay the cost of their illness at the time it occurs. The other half fall into the category of those whose income is so low that they cannot properly be expected to purchase prepayment protection.

PROGRESS MADE IN INSURANCE

The full significance of what has been accomplished already in the insurance field is not shown by a comparison of total hospital and medical costs with the percentage of coverage that now prevails. One of the principal effects of insurance has been a leveling process that takes off the peak of medical expense and fills in the valley by averaging the overall costs.

For example, the average cost for hospital care per person hospitalized is $148. If insurance only accomplished the leveling process so that everyone paid this average figure, there would be relatively little hardship. But insurance does more by paying a substantial proportion of the bill.

In addition, very encouraging progress has been made in the sale of major medical expense insurance or so-called catastrophic illness insurance. These plans are comparatively young, but already more than a million such policies have been written. The extraordinary expansion of prepayment voluntary health insurance during the past 15 years, particularly during the past two to three years, gives us reason to believe that further expansion in the number covered and the extent of coverage will continue. There are approximately eight hundred insurance agencies engaged in selling health insurance in a highly competitive field. Further extensions will continue as rapidly as sound actuarial experience is required, and as more and more people are induced to give the purchase of health insurance its proper place in their budget.

Through the medium of the Federal Reinsurance Corporation the Department of Health, Education, and Welfare proposes to broaden health insurance coverage by reducing exclusions, making benefits more comprehensive, reaching into the area of catastrophic illness, increasing the number of hospital days allowed, eliminating certain age restrictions, covering a portion of the uninsurable and by including in insurance the cost of providing early diagnosis and treatment of chronic disease. These are all admirable objectives. But can they be accomplished under the principles of insurance? One can not insure against death, for death is certain; but one can insure against the unpredictable factor of when death will occur or what will cause it. I could buy very cheaply at my age insurance against death or crippling from poliomyelitis, but insurance against death or disability from a long list of the diseases common in my age group, such as cancer, heart trouble, diabetes, arteriosclerosis, and paralysis, would be extremely expensive. Reinsurance will not make insurance any cheaper. In fact, while it makes it more dependable, it increases the cost, since the premium charge for reinsurance has to be added to the premium paid by the individual policyholder.

Under our present system there has been rapid progress in the direction of covering greater numbers, extending benefits and including a wider range of individuals who present a greater than average risk. This has come about through the general improvement in the health of our people, which is re-

flected in the accumulated actuarial data and by adoption of the principle of coinsurance and the deductible factor.

We have to recognize that there is a large group of medically uninsurable people. While this group is being whittled down and can be whittled down further, there is a hard core that remains. At present it is made up of a major fraction of the more than thirteen million aged persons, the totally disabled, and a portion of the temporarily disabled, the public assistance cases, a considerable number of the unemployed, and the indigent. The individuals in these groups are entitled to and should have access to good medical care. This care should be paid for by direct payment at the time that illness occurs. Those who are unable to pay for their own care are now being paid for by private philanthropy and by local and state governmental agencies. This is being well done in certain areas and poorly done in others. This factor, however, does not militate against the validity of this prinicple. It does mean that every possible effort should be made in every locality and in every state to improve this particular aspect of the medical care program. It is fallacious, however, to assume that any form of insurance can economically cover these groups. It can be done by compulsory national insurance so-called, but that method ceases to be insurance and becomes simply a Federal medical plan supported by taxed funds.

To attempt to insure the non-insurable group would be economically unsound and can only be accomplished by subsidy. Subsidized insurance would certainly impair and perhaps destroy voluntary insurance.

There are a number of grounds for a reasonable fear of the effect of the Federal government's entrance into the area of reinsurance of health insurance plans. I am sure that the proponents of this plan are sincere in their statements that there is no element of subsidy involved. I am not sure that they are wise enough or strong enough to keep it out. In fact, on a small scale, it is already in. The operating expenses of the Federal Reinsurance Corporation will come from general tax funds for a period of five years. It will be in competition with private and non-profit agencies within this same field that pay their own operating costs. There is a larger danger, however, in that once the machinery is set up, there will be a popular demand for a subsidy, through this corporation, for insuring the low income group. Once this occurs, further progress upward on the economic scale of governmental subsidized insurance is a simple matter of lengthening the yardstick by which indigency is measured. The one check upon expansion of the plan is the provision that corporations will pay only 75 per cent of the losses of the plan. This will be a strong deterrent against plans being put forward that do not have a reasonably sound actuarial basis. If this deterrent works, the corporations will probably do little business and cease to be an important factor unless it moves into the field of subsidy.

The power granted the Secretary of Health, Education, and Welfare under this bill is rather extraordinary. An advisory committee and its chairman are appointed by the Secretary. It reports only to the Secretary and is responsible to the Secretary alone. The Secretary has the power to declare, when in his judgment, a private agency is performing a particular insurance function that will further the purposes of the bill. How this fits into the "no competition" statement in the bill is somewhat difficult to understand.

It has long been this nation's policy to leave to the states the supervision and control of insurance. Entrance of the Federal Government into this area may well be viewed with some misgivings. This is particularly true when subsidy becomes a part of the program, since an element of Federal control will surely follow Federal subsidy.

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